THE CONGRESSIONAL OUTLOOK*

HON. HARRISON A. WILLIAMS, JR.

U. S. Senator, State of New Jersey
Chairman, Senate Committee on Labor and Public Welfare
Member, Senate Special Committee on Aging
Washington, D.C.

I SHALL give one man's view of how we are approaching some of our responsibilities to our older citizens. The Nixon administration's new budgetary and legislative proposals affecting the health and well-being of our nation's older citizens have created waves of astonishment and disarray among the aging, largely because no group in our society today is more in need of quality health care than the 21 million Americans who are over age 65.

Their average health expenditures amount to $981 a year—almost $1,000—for persons who are living on limited, fixed incomes. This is nearly seven times the average cost for persons younger than 19 and about three times that for individuals between the ages of 19 and 64. Older Americans account for 27% of national health expenditures, but they represent only 10% of the population. Yet most Americans believe that the hospital and medical bills of the elderly are paid almost entirely by Medicare. The older American knows better.

Today Medicare covers only 42% of the total health costs of the elderly, and this percentage has shrunk steadily since President Richard M. Nixon took office. In 1969 Medicare paid for nearly 46% of the medical expenditures of the elderly. If the administration's proposed cutbacks become law, this percentage will drop sharply.

The most startling fact is that older Americans now pay more in out-of-pocket payments for medical treatment than in the year before Medicare became law. At that time they paid $234 from their own resources. Today that figure has soared to $278, or $42 more than in 1966. These facts clearly indicate that a health-care crisis of major proportions still threatens the elderly. Eight years ago the enactment of the Medicare law brought peace of mind to millions of older Americans. It was a

*Presented in a panel, National Policy: The Background of Current Issues, as part of the 1973 Annual Health Conference of the New York Academy of Medicine, *Problems of Older People: Forced Idleness, Impoverishment, Ill Health, Isolation,* held at the Academy April 30 and May 1, 1973.

hard fight and a well-earned victory, but this essential program has been eroded in many ways by restrictive administrative regulations, gaps in coverage and, of course, inflationary pressures.

To make matters worse, the administration has proposed to saddle the elderly and disabled with new costs for hospital and medical treatments. These proposals were couched in euphemistic language in the president's latest budget, but they would have a devasting impact upon older Americans.

Just what does the administration propose? First, it wants the elderly and disabled to pay for hospital room-and-board charges for the first full day, plus 10% of all subsequent charges. You know that the first day's charges is the heaviest of all. Today Medicare patients pay a $72 deductible and nothing thereafter until, of course, the hospitalization reaches the 61st day.

Second, the administration would make the aged pay the first $85 of doctors' bills, instead of the present $60 deductible. Third, after this deductible is met, the administration would burden Medicare patients with 25% of the balance, where they now pay 20%. The net effect of these proposals is that aged and disabled Americans would have their health-care costs increased by more than one billion dollars.

A few weeks ago a panel from New York City told the Senate Committee on Aging what these proposed cutbacks would mean in human terms. I shall share with you two of their examples. The average stay for an elderly person in a New York City hospital is about 21 days. Today this patient would pay $72. However, we are told that, using very conservative projections, this same patient would pay $330 under the administration's proposals. Doctor's bills would also be more costly for the elderly if the administration plan prevails. In an example presented to the Committee on Aging, it was estimated that an aged patient with congestive heart failure now pays about $225 for the year. But if these proposals should become law this out-of-pocket payment would jump to $285, an increase of nearly one third.

The secretary of the Department of Health, Education, and Welfare (HEW) argues that these changes are necessary to encourage greater cost-consciousness. But older Americans living on less than $100 per month in Social Security benefits certainly do not need this type of encouragement. They already, as we all know, are struggling desperately, trying to make ends meet. Additional health-care costs easily could

break them. Moreover, physicians, not elderly patients, determine the mode and timing of health-care utilization. This is appropriate because they are competent and trained to make these judgments on a professional basis.

Finally, in this area I just cannot believe that Americans of any age are anxious to spend time in a hospital. They are there, almost without exception, because it is necessary, not because they like it. Of course, there are a few exceptional situations. For example, three years ago I was hospitalized with no telephone available and I must admit that I was not too eager to get out. But these exceptions are rare.

Further, the secretary of HEW maintains that the elderly are better able to pay for new cost-sharing because of recent Social Security increases. He overlooks some harsh facts of life. More than three million persons over 65 have incomes which fall below the poverty line: the minimum standard of a little more than $2,000 for a single aged person and $2,600 for an elderly couple. A majority of the elderly, nearly 11 million in all, now subsist on incomes below the Department of Labor's intermediate budgets for older Americans.

Congress did not intend first to help the elderly with the recent, much-deserved Social Security increase and then torpedo it by approving staggering increases in their health-care costs. The Congress will not pass these short-sighted and ill-advised administration proposals. That was made clear on March 1, 1973, when I joined with all the other chairmen of the Senate's standing committees to state our unequivocal opposition to these proposals. Those of us participating represented all sections of the country and the whole spectrum of philosophy. My speech followed that of Senator James O. Eastland; that indicates the range of opinion represented. Yet, on this issue there was unanimity that day—a unanimity determined to let the president know that the Senate was not interested in proposals which could cut Medicare coverage of the elderly's health-care expenditures to as low as 25%.

There are also other areas that are highly important to all of us, particularly to those who gather in a conference of this nature. The deficiencies in our health-care system are basic to our discussion here. High costs, as crucial as they are, represent but one dimension of the health-care crisis now facing older Americans. Another dimension is society's pervasive attitude of therapeutic pessimism in the treatment of aged people. Overwhelming evidence makes it clear that this pessimism is not

warranted, and will be less warranted if we properly apply our resources to research. Quite to the contrary, most physical as well as mental conditions of older Americans are treatable.

The elderly also suffer because the fragmentation of medical services is intensifying their health-care dilemma, especially in rural areas and inner cities, where we all know that a high concentration of poverty among the aged continues to be found. The result is that quality health care is often beyond their reach geographically. Yet these individuals frequently have the greatest need for effective medical treatment. Collateral problems add to their burdens. Transportation is one of the most striking examples. Today many older Americans live under a form of house arrest; only about 42% are licensed to drive and public transportation systems frequently are off limits to the elderly because they are inaccessible, inconvenient, or too costly.

The Committee on Aging has begun a comprehensive inquiry into barriers to health care for older Americans, and I believe that, if this work that we are now embarked upon is as successful as some of the other activities of the Committee, we shall break down some of these barriers. William R. Hutton can tell you that some of those special committee studies and reports were required reading and mandatory text materials for the *White House Conference on Aging*. I hope we can be as useful as we try to eliminate some of these barriers.

In 1972 the 92nd Congress approved several landmark measures to improve the economic well-being of older Americans. A 20% Social Security raise was enacted, the largest dollar increase in the entire history of the program. A cost-of-living mechanism was added to the program to make Social Security benefits inflation-proof—not fool-proof, but at least offering automatic protection against inflation.

Major reforms incorporated in H.R.I., including increased payments for elderly widows, the liberalization of the retirement test, a new supplemental-security-income program to build a floor under the income of the aged, and other measures. I sincerely hope that this Congress can produce achievements of like magnitude in the area of health care for the elderly. We owe this to our nation's older citizens. With the help of all of you and groups like yours that I hope are gathered throughout the country from time to time, we together shall be able to keep the light shining on the problem until it leads to enactment of these programs.